I. National Correct Coding Initiative: Date-of-Service Medically Unlikely Edits

Currently, all Medically Unlikely Edits (MUEs) in the Medicaid National Correct Coding Initiative (NCCI) are claim-line edits, meaning that the MUE is applied independently to each line of a claim. However, starting in April 2013, the Medicare NCCI program began converting most of its claim-line MUEs to date-of-service (DOS) MUEs. A date-of-service MUE sums the submitted units of service for a given HCPCS / CPT code on all lines of the presenting claim and all paid claim lines on claims in history that are billed by the same provider for the same beneficiary for the same DOS.

CMS has decided that it will incorporate the Medicare DOS MUEs into the Medicaid NCCI program. This process will begin with the quarterly Medicaid NCCI edit update for April 1, 2015.

Information defining which MUEs are date-of-service MUEs and which are currently still claim-line MUEs will be included in a new field in the quarterly Medicaid NCCI edit files that are posted on the Medicaid NCCI webpage on the Medicaid.gov website (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html).

The new field in the quarterly Medicaid NCCI edit files will be titled “MUE Adjudication Indicator” (MAI).

MUEs that are claim-line edits will have an MAI of “1”. MUEs that are date-of-service MUEs will have an MAI of “2” or “3”.

An MAI of “2” is assigned to an MUE only if the properly reported units of service submitted for that HCPCS / CPT code by the same provider for the same beneficiary on the same date of service would rarely, if ever, exceed the MUE value. For example, it would not be proper to report more than one unit of service for an appendectomy. Similarly, a HCPCS / CPT code which describes the unit of service for the code as the “initial hour” would not be properly reported with more than one unit of service by the same provider on the same date of service.

An MAI of “3” is assigned to an MUE if the properly reported units of service submitted for that HCPCS / CPT code by the same provider for the same beneficiary on the same date of service would exceed the MUE value only in unusual circumstances. For example, it would be unusual to report more than one unit of service on the same date of service for a thoracotomy performed for post-operative complications. In those unusual situations in which the properly reported units of service exceed the MUE value for the code, individual case exceptions can be made if adequate documentation is submitted to support the medical necessity for the reported services.

Currently, CMS has reviewed the MUEs for over half of the approximately 16,000 HCPCS / CPT codes and, as a result, a high percentage of those have been converted to date-of-service MUEs. Those edits will be incorporated in the Medicaid NCCI program. Decisions for the remaining codes will be made and incorporated in the NCCI edits gradually over at least several quarters. Until the MUEs for individual codes have been reviewed, they will remain as claim-line MUEs.

II. Specific Modifiers for Distinct Procedural Services

I. Per CMS transmittal 1422 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf), effective January 1, 2015:

CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) as follows:

- XE - Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS - Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- XP - Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XU - Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

These modifiers, collectively referred to as -X{EPSU} modifiers, define specific subsets of the -59 modifier. CMS will not stop recognizing the -59 modifier but notes that CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available. CMS will continue to recognize the -59 modifier in many instances but may selectively require a more specific - X{EPSU} modifier for billing certain codes at high risk for incorrect billing.

This was because "This modifier [59] is associated with considerable abuse and high levels of manual audit activity; leading to reviews, appeals and even civil fraud and abuse cases.

Further information is available at the following websites:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.pdf
http://news.aapc.com/index.php/2014/08/cms-introduces-four-new-modifiers-in-lieu-of-modifier-59/

II. The claim-adjudication rules for NCCI Procedure-to-Procedure (PTP) edits specify that, if an edit pair has a Correct Coding Modifier Indicator (CCMI) of "1" and, if a designated PTP-associated modifier is appropriately appended to either code of the PTP edit pair, then the edit should be bypassed. A list of the current PTP-associated modifier is found in the Medicaid NCCI Edit Design Manual available on the Medicaid.gov website at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2014-Medicaid-NCCI-Edit-Design-Manual-Rev-3-14.pdf
These four new HCPCS modifiers will be established on January 1, 2015, and will be added to the list of PTP-associated modifiers for Medicaid claims.
These modifiers describe clinical situations that currently are indicated by appending modifier 59 – "Distinct Procedural Service". However, analysis has identified that modifier 59 is often misused to bypass PTP edits, partly because it is so non-specific. The new modifiers were established so that providers could specify more clearly the situations in which PTP edits with a CCMI of "1" are eligible to be bypassed.
Modifier 59 will remain a valid PTP-associated modifier. However, the coding instructions for modifier 59 specify that it should be used "only if no more descriptive modifier is available". Therefore, providers should use one of the new modifiers, instead of modifier 59, if the clinical situation described by one of the new modifiers is present.

III. Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs)

Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs) must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-of-benefits (COB) transactions.

Claim adjustment reason codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed.

Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.

Providers may find these codes printed on their paper and/or electronic 835 remittance advice documents.

The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers. The RARC list is updated 3 times a year – in early March, July, and November . A national code maintenance committee maintains the CARCs. That Committee meets at the beginning of each X12 trimester meeting and the updated list is posted 3 times a year around early March, July, and November.

Both code lists are posted at ***http://www.wpc-edi.com/Codes*** Providers are encouraged to check this website so they may read the full message associated with each code and so that they may be aware of any additions, deletions or modifications.

IV. National Uniform Billing Committee (NUBC)

The National Uniform Billing Committee (NUBC)(http://www.nubc.org/) oversees and maintains the data elements used on the UB claim form and annually releases the Official UB-04 Data Specifications Manual. This manual contains updated specifications for the data elements and codes included on the UB-04 claim form, and used in the electronic HIPAA Institutional 837 Health Care Claim transaction standard.
Providers who submit claims using the UB form or the 837 Institutional transaction are encouraged to maintain a subscription to the manual and are referred to the NUBC website for more information: http://www.nubc.org/NUBC can also be contacted at 1-800-242-2626

Recently NUBC has released a number of changes regarding data elements which NM Medicaid is now implementing. Changes include:

A. New Condition Codes

For NM Medicaid, condition codes are optional values which can be placed in form locators 18-28 of the UB-04 claim form.

Cesarean section / induction conditions codes:
81 - C-sections or inductions performed at less than 39 weeks gestation for medical necessity.
82 - C-sections or inductions performed at less than 39 weeks gestation electively.

83 - C-sections or inductions performed at 39 weeks gestation or greater.
Accordingly, NM Medicaid has moved the current definitions of codes 81-83, below, to codes 97-99 (which are currently undefined):

81 ☐ 97 Dual Elig Mcaid Mcare B Only
82 ☐ 98 Dual Elig Mcaid Mcare A&B
83 ☐ 99 Rural Hlth Clinic/FQHC

Providers are reminded that the Medical Assistance Division released supplement 13-05 last year which contained information related to limiting payment for inductions and c-sections that are not medically necessary and other important topics. Providers can review supplements on the MAD website : http://www.hsd.state.nm.us/by clicking on 'Providers' , then 'New Mexico Administrative Code Program Rules and Billing' and then 'Supplements to NMAC Program Rules' or going here: http://www.hsd.state.nm.us/providers/Registers_and_Supplements.aspx

Hospice Condition Codes

There is a new hospice condition code "52" for out of service area discharges.
The code is used when the patient is discharged for moving out of the hospice service area, including patients admitted to a hospital without contractual arrangements with the hospice.
Occurrence code 42 is defined by the NUBC as "date of discharge/hospice term date (hospice only)".
Hospice providers should discontinue use of occurrence code 42 for situations when a provider initiates the termination of hospice care and only use occurrence code 42 to indicate a discharge due to a patient revocation, in accordance with the existing NUBC instructions.
Additionally, hospice providers should use new NUBC condition code 52 to indicate a discharge due to the patient's unavailability/inability to receive hospice services from the hospice which has been responsible for the patient. In such a circumstance, the patient is considered to have moved out of the hospice's service area.
The table below summarizes how hospice discharges could be coded :

Discharge Reason	Coding Required in Addition to Patient Status Code
Beneficiary Revokes	Occurrence Code 42
Beneficiary Transfers Hospices	Patient Status Code 50 or 51; no other indicator
Beneficiary No Longer Terminally Ill	No other indicator
Beneficiary Discharged for Cause	Condition code H2
Beneficiary Moves Out of Service Area	New condition code 52

Other New Conditions Codes:

45 - Ambiguous Gender Category
47 - Transfer from Another Home Health Agency
49 - Product Replacement within Product Lifecycle—Replacement of product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly—warranty.
50 - Product Replacement for Known Recall of a Product—Manufacturer or Food and Drug Administration (FDA) has identified the product for recall and therefore replacement.
51 - Attestation of Unrelated Outpatient Non-diagnostic Services
52 - Out of Hospice Service Area (Effective 7/1/12) [see item #3, above]
59 - Non-primary ESRD Facility
60 - Operating cost day outlier

B4 - Admission Unrelated to Discharge on Same Day
BP - Gulf Oil Spill of 2010
DR - Disaster Related
H2 - Discharge by a Hospice Provider for Cause
P1 - Do Not Resuscitate Order (DNR)
P7 - Direct Inpatient Admission from Emergency Room
W0 - United Mine Workers of America (UMWA) Demonstration Indicator
W2(a) - Duplicate of Original Bill
W3(a) - Level I Appeal
W4(a) - Level II Appeal
W5(a) - Level III Appeal

B. New Type of Bill series 78X for Licensed Freestanding Emergency Medical Facilities

Licensed Freestanding Emergency Medical Facilities are emerging as a new model in health care delivery. If attached to a hospital, the bill type is often reported as 131 (hospital outpatient, admit through discharge). However, more and more facilities are being licensed as facilities that are NOT affiliated with hospitals and are insisting on using the UB with a bill type of 0731 (freestanding clinic). The concern was raised that if these are truly a separate type of facility, and not really a freestanding clinic, a new bill type should be implemented.
NUBC voted to approve the use of a new Type of Bill for Licensed Freestanding Emergency Medical Facility.

For NM Medicaid, type of bill codes are required values which can be placed in form locator 4.

C. Point of Origin for Admission or Visit Changes

NUBC changed the name of the 'Admit Source' field (also known as the Admission or Visit Referral Source field) to "Point of Origin for Admission or Visit". These are codes indicating the point of patient origin for this admission or visit.

Many of the codes' descriptions also changed:
1 - Non-Health Care Facility Point of Origin (Physician Referral)
2 - Clinic or Physician's Office Inpatient
5 - Transfer from a Skilled Nursing Inpatient Facility (SNF), Intermediate Care Facility (ICF) or Assisted Living Facility (ALF)
7 – Previously: Inpatient: The patient was admitted to this facility after receiving services in this facility's emergency room department.
Now: Discontinued - Reserved for assignment by the NUBC
A – Previously: Transfer from a Rural Primary Care Hospital
Now: Discontinued - Reserved for assignment by the NUBC
B – Previously: Transfer from another home health agency
Now: Discontinued - replaced with Condition Code 47
C – Previously : Readmission to same home health agency
Now: Discontinued - - Reserved for assignment by the NUBC

For NM Medicaid, point of origin codes are optional values which can be placed in form locator 15.

D. Occurrence Code Changes

For NM Medicaid, occurrence codes (and their associated dates) are optional values which can be placed in form locators 31-34.

Definition changes:
50 - Assessment Date [Previously - Date Medicare Paid]
51 - Date of Last Kt/V Reading [Previously - Date Medicare Denied]

52 - Medical Certification / Recertification Date [Currently - Date Reviewed]
54 - Physician Follow-up Date [Currently - Date of Discharge IP Rehab]
55 - Date of Death [Currently - Insurance Paid Date]

New occurrence codes:
A4 - Split Bill Date - Date patient became eligible due to medically needy spend down (sometimes referred as “Split Bill Date”).

Occurrence Span Code Changes
For NM Medicaid, occurrence span codes (and their associated dates) are optional values which can be placed in form locators 35-36.

New codes:
80 - Prior Same-SNF Stay Dates for Payment Ban Purposes
81 - Antepartum Days at Reduced Level of Care
M0 - QIO/UR Approved Stay Dates
D5 - Last Kt/V Reading

E. Patient Discharge Status Code Changes
For NM Medicaid, Patient Status Codes are required for inpatient, nursing home and hospice claim and can be placed in form locator 17. The NUBC has approved 16 new patient discharge codes with an effective date of October 1, 2013.

New patient status code 69 (Discharged/transferred to a designated disaster alternative care site) will be added as a new code. Discharge codes 81-95 were adapted after existing codes but with "a Planned Acute Care Hospital Inpatient Readmission" added in the description. Readmission is defined as "An intentional readmission after discharge from an acute care hospital that is a scheduled part of the patient's plan of care."